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No. 04-623

# In the Supreme Court of the United States

**JOHN ASHCROFT, Attorney General, et al.,**

**Petitioners,**

**v.**

**STATE OF OREGON, et al.,**

**Respondents.**

**Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit**

## BRIEF FOR RESPONDENT STATE OF OREGON IN OPPOSITION

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## QUESTION PRESENTED

Exercising its traditional police powers, Oregon enacted laws and regulations that allow physicians to prescribe and pharmacists to dispense Schedule II controlled substances to competent, terminally-ill adults who may use them under strictly regulated conditions to choose the time, place, and manner of their impending deaths. In enacting and amending the Controlled Substances Act (CSA), did Congress clearly authorize the Attorney General to determine that physicians and pharmacists acting in accordance with those Oregon laws have violated the CSA?

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## JURISDICTION

The judgment of the Court of Appeals was entered on May 26, 2004. A petition for rehearing was denied on August 11, 2004. Pet. App. 98a-99a. The petition for a writ of certiorari was filed on November 9, 2004. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

## STATEMENT

In 1994, the people of Oregon enacted by initiative the Death With Dignity Act (DWDA). Or. Rev. Stat. §§ 127.800 through 127.995. The DWDA establishes tightly controlled procedures under which competent, terminally-ill adults who are under the care of an attending physician may obtain a prescription for Schedule II controlled substances in sufficient kind and quantity to allow them to control the time, place, and manner of their own impending death. Or. Rev. Stat. § 127.805; Pet. App. 163a.[1] The attending physician must determine, among other things, the patient's mental competence, Oregon residence, and diagnosis and prognosis. Or. Rev. Stat. §

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[1] To qualify as "terminally ill" a person must have "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." Or. Rev. Stat. § 127.800(12).

127.815; Pet. App. 163a-165a. The attending physician must inform persons requesting those substances of their diagnosis and prognosis, the risks and probable results of taking the medication, and alternatives to taking their own lives, including, but not limited to, hospice care and pain relief. Or. Rev. Stat. § 127.800(7); Pet. App. 162a. A consulting physician must confirm the attending physician's medical opinion. Or. Rev. Stat. § 127.800(8); Pet. App. 162a. Once a request from a qualifying patient has been properly documented and witnessed, and all waiting periods have expired, the attending physician may prescribe, but not administer, medication to enable the patient to end his or her life in a humane and dignified manner.[2] The DWDA immunizes physicians and pharmacists who act in compliance with its comprehensive procedures from civil or criminal sanctions, or professional disciplinary actions based on that conduct. The

[2] The DWDA is sometimes referred to as authorizing "physician-assisted suicide." That description is potentially misleading. As described in the text, the DWDA authorizes physicians to prescribe and pharmacists to dispense controlled substances that will permit a patient to choose a painless death, but it does not authorize either to administer those substances to the patient. Moreover, as also described in the text, only a very limited category of persons qualify in a very limited number and type of circumstances to receive those substances. It is only within the carefully circumscribed boundaries established by those limitations that the phrase "physician-assisted suicide" can be considered accurate as applied to the DWDA.



DWDA also requires healthcare providers to file reports with the State documenting their actions.[3]

When some members of Congress complained to then-Attorney General Janet Reno that the DWDA authorized a use of controlled substances that violated the Controlled Substances Act (CSA), she disagreed. After a "thorough and careful review" by the Justice Department, Attorney General Reno concluded that the CSA was intended "to prevent both the trafficking in [controlled] substances for unauthorized purposes and drug abuse. The particular drug abuse that Congress sought to prevent was that deriving from the drug's 'stimulant, depressive, or hallucinogenic effect on the central nervous system.' 21 U.S.C. § 811(f)." Supp. App. 3-4. Attorney General Reno could find no evidence that, "in the CSA, Congress intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice." *Id.* at 4. The Attorney General noted that the CSA was "essentially silent" about "regulating the practice of medicine that involves legally available drugs," with one exception dealing with treating addicts. "Even more fundamentally, there is no evidence that

[3] Since November 1997, when the people of Oregon approved the DWDA for the second time, a total of 171 patients have self-administered Schedule II controlled substances prescribed under the Act. *See* Sixth Annual Report on Oregon's Death with Dignity Act, Table 1 p. 19 (March 10, 2004), http://www.dhs.state.or.us/publichealth/chs/pas/ar-index.cfm (as visited December 14, 2004).

Congress, in the CSA, intended to assign the [Drug Enforcement Agency] the novel role of resolving the 'earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide,' *Washington v. Glucksberg*, 117 S. Ct. 2258, 2275 (1997), simply because that procedure involves the use of controlled substances." *Ibid.* Determining whether conduct permitted by the DWDA "falls outside the legitimate practice of medicine and is inconsistent with the public interest," "are fundamental questions of morality and public policy" that are "well beyond the purposes of the CSA." *Ibid.*[4]

But as the Court of Appeals noted, "[w]ith a change of administrations came a change of perspectives." Pet. App. at 8a. Relying primarily on a regulation providing that a prescription for a controlled substance is "effective" only if issued for a "legitimate medical purpose,"

[4] Attorney General Reno's view that Congress delegated only limited authority to the Attorney General to address medical practices was applied for years by the DEA in administering the CSA. *See, e.g.*, Wesley G. Harline, M.D., Continuation of Registration with Restrictions, 65 Fed. Reg. 5665 (2000) (declining to revoke physician's CSA registration where there were differences of opinion in the medical community over whether a particular use of controlled substances served any legitimate medical purpose because "it is not DEA's role to resolve these differences and set the standard for the medical community"); William F. Skinner, M.D., Continuation of Registration, 60 Fed. Reg. 62,887 (1995) (DEA will not attempt to decide whether a particular practice serves a legitimate medical purpose if "the medical community has not reached a consensus" on the issue).



21 C.F.R. § 1306.04, Attorney General John Ashcroft issued a directive (Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607; Pet. App 100a through 105a), concluding that physicians who prescribe controlled substances in compliance with the DWDA violate the CSA, making them subject to sanctions including criminal prosecution and loss of their ability to prescribe controlled substances.[5]

Seeking to protect not only its physicians, but also its sovereign ability to implement the will of Oregon's people by providing competent, terminally-ill adults with a right Oregonians twice voted to confer, Oregon brought suit in the United States District Court for the District of Oregon. The State asserted, in part, that the Ashcroft Directive exceeded the Attorney General's authority because Congress did not intend to authorize the Attorney General to override a State's regulation of the practice of medicine.[6] A doctor, a pharmacist, and several terminally-ill Oregonians intervened.

[5] The CSA applies to "practitioners," which, in general terms, it defines to include physicians, dentists, veterinarians, scientific investigators, pharmacists, and others who are licensed by the United States or the jurisdiction in which they practice to distribute, dispense, or conduct research on or analysis of controlled substances. 21 U.S.C. § 802(21); Pet. App. 149a. For convenience, and because Oregon's law applies only to physicians and pharmacists, this brief generally refers to physicians.

[6] Oregon also asserted that if Congress had intended to displace the State's authority in this particular context, it would have exceeded its power under the Commerce Clause.

The District Court agreed that nothing in the CSA supports the Attorney General's conclusion that Congress intended to substitute his judgment for the historic authority of the State to determine the scope of legitimate medical practice. Consequently, the court permanently enjoined enforcement of the Ashcroft Directive. The District Court began with this Court's opinion in *Washington v. Glucksberg*, 521 U.S. 702 (1997), which, the court noted, acknowledged the "earnest and profound debate" about end-of-life treatment occurring in the States. Pet. App. 66a-67a. Although the District Court agreed that the CSA gives the Attorney General and Drug Enforcement Agency (DEA) "broad authority to regulate controlled substances," the court concluded: "No provision of the CSA, however, alone (as defendants urge) or viewed as a 'symmetrical and coherent scheme' demonstrates or even suggests that Congress intended to delegate to the Attorney General or the DEA the authority to decide, as a matter of national policy, a question of such magnitude as whether physician-assisted suicide constitutes a legitimate medical purpose or practice." Pet. App. 87a. Nor could the court find support for the Attorney General's position in the legislative history of the CSA. Rather, that history overwhelmingly supported the conclusion "that Congress' intent was to address problems of drug abuse, drug trafficking, and diversion of drugs from legitimate channels to illegitimate channels." *Id.* at 89a-90a. Finally, the court noted that none of the cases on which the Attorney General relied involved doctors or

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Neither the District Court nor the Court of Appeals found it necessary to reach that question.



pharmacists who were acting in compliance with state law. *Id.* at 92a-93a, *citing*, *inter alia*, *United States v. Moore*, 423 U.S. 122 (1975). In concluding, the court stated: "The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states. * * * The CSA was never intended, and the USDOJ and DEA were never authorized, to establish a national medical practice or act as a national medical board." Pet. App. 94a-95a.

The Attorney General appealed, and the Court of Appeals affirmed. That court, too, began its analysis with *Glucksberg*. Pet. App. 9a. The court noted this Court's statement that determining whether to permit physicians to aid those who wished to hasten death "belongs among state lawmakers," *ibid.* (citing *Glucksberg*, 521 U.S. at 735) in the "'laboratory' of the States." *Ibid.* (quoting 521 U.S. at 737 (O'Connor, J., concurring)). As the District Court had, the Court of Appeals explained that States bear and historically have borne primary responsibility for regulating medical care. Pet. App. 10a. Therefore, unless the federal statute in question is "unmistakably clear," the courts will not conclude that Congress intended to alter that federal balance. *Id.* at 11a. And, as the District Court did, the appeals court concluded that "Congress has provided no indication—much less an 'unmistakably clear' indication—that it intended to authorize the Attorney General to regulate" in this context. *Id.* at 12a. The Court of Appeals' review of the legislative history confirmed that Congress was concerned with drug abuse, drug addiction, and the diversion of controlled substances out of legitimate channels, not with substituting the Attorney General for state regulators. *Id.*

at 18a-20a. Because Congress had not expressed its clear intention to replace the States as the regulators of medical practice, the court concluded that it was "under no obligation to defer to the Attorney General's interpretation of his role under the statute and its implementing regulations." *Id.* at 21a. And the court noted that this Court refused to extend deference to an agency's interpretation of a regulation "where, as here, it conflicts with the agency's previous interpretation of the same regulation." *Id.* at 23a, n. 11, *citing Norfolk S. Railway Co. v. Shanklin*, 529 U.S. 344, 356 (2000), and *Solid Waste Agency of Northern Cook Cty. v. Army Corps of Engineers*, 531 U.S. 159, 168 (2001).

The dissenting opinion concluded that the Attorney General's interpretation of the "legitimate medical purpose" regulation was valid and controlling. Generally rejecting the majority's analysis, the dissent determined that the CSA was not limited to combating drug abuse, Pet. App. 34a-36a; that Congress did not intend to preserve the States' traditional authority over the practice of medicine if that practice involved controlled substances, *id.* at 36a; and that the "clear statement" rule does not apply to the CSA. *Id.* at 45a-47a. Ultimately, the dissent concluded that the Ashcroft Directive was an interpretation of the agency's "legitimate medical purpose" regulation, not an interpretation of the CSA itself, *id.* at 54a, and it was therefore entitled to be judged under a "highly deferential standard of review." *Id.* at 55a. Applying that standard, the dissent had no difficulty in finding the Ashcroft Directive to be conclusive. *Id.* at 56a.



## ARGUMENT

Because the DWDA is unique to Oregon, petitioner is understandably unable to claim that the Court of Appeals' decision in this case conflicts with decisions of other circuits. Consequently, he is left to assert that this Court should grant review because the Court of Appeals' opinion is inconsistent with this Court's cases and therefore wrong, that the opinion threatens federal supremacy, and that this case has national significance because it involves a ground-breaking policy choice with which many disagree. But neither the permissibility nor the wisdom of Oregon's policy choice is at issue here.[7] What is at issue—whether Congress authorized the Attorney General to overrule a State's decision about specific medical uses of controlled substances that admittedly have approved medical uses—is a narrow question of statutory construction calling for the application of settled principles. And notwithstanding petitioner's assertions, the Court of Appeals correctly applied this Court's precedents. Review by this Court is therefore not warranted.

1. The Attorney General places the policy choice embodied in the DWDA at the forefront of his argument. Pet. Cert. 11-13. He describes Oregon's decision to permit physicians to assist mentally-competent, terminally-

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[7] Oregon successfully defended a direct challenge to the substance of the DWDA shortly after that law's enactment, *Lee v. State of Oregon*, 107 F.3d 1383 (9th Cir. 1997), *cert. den.* 522 U.S. 927 (1997), and petitioner does not suggest that the DWDA is invalid. He asserts only that his authority over controlled substances allows him to prevent their use for purposes authorized by the Oregon law.

ill adults in choosing the time, place, and manner of their own impending deaths as a radical departure from long-accepted legal and ethical norms that is at odds with the decisions of the remaining states, the opinions of certain medical associations, and tradition. *Ibid.* Oregon does not, nor could it, deny that its choice is controversial; this Court has already acknowledged the serious, complex, and unsettled nature of the question presented by end-of-life decisions, particularly in the light of modern medical means of prolonging life. *Glucksberg*. But even if Oregon conceded that it stood alone in its views about end-of-life care,[8] whether a State can authorize physicians to assist those who seek to avoid intolerable pain and loss of control and dignity at the end of their lives is not at issue here. At most, this case is about the means those physicians may use. Consequently, the only questions this case presents are whether, in enacting the CSA, Congress intended to supercede the States' historic police powers over the practice of medicine, and, even if it did, whether it intended to authorize the Attorney General to decide the specific uses state-licensed physicians may make of controlled substances that admittedly have approved medical uses.

2. Suggesting that this case involves a broad attack on a generally accepted principle, *see Glucksberg*, 521 U.S. at 770 (Souter, J., concurring in the judgment), the petition expansively asserts that the Court of Appeals' decision

[8] It does not. As this Court recognized in *Glucksberg*, the subject addressed by the DWDA is an issue of earnest, widespread, and ongoing debate among citizens, lawmakers, ethicists, and medical professionals throughout the nation.



threatens to give States supremacy over federal law and turn the "proper relationship between the federal and state governments under the Constitution on its head." Pet. Cert. 9. That, too, overstates the issue. This Court has explained that, under our federal system, the promise of liberty lies in "the tension between federal and state power." *Gregory v. Ashcroft*, 501 U.S. 452, 459 (1990). That tension necessarily creates questions about "who gets to decide." *See* Pet. App. 9a. The Supremacy Clause, U.S. Const., Art. VI, § 2, even if not the ultimate weapon, certainly gives Congress an obvious advantage in most contests about decision-making authority within the federal system. *See Gregory*, 501 U.S. at 460. Nevertheless, the States "retain substantial powers under our federal scheme, powers with which Congress does not readily interfere." *Raygor v. Regents of the University of Minnesota,* 534 U.S. 533, 544 (2002).

When Congress legislates in those traditionally state-controlled areas, it "alter[s] the usual constitutional balance between the States and the Federal government." *Id.* at 543 (internal quotation marks omitted). Even where there is no doubt that Congress *can* do that, "it must make its intention to do so unmistakably clear in the language of the statute." *Ibid., quoting Will v. Michigan Dept. of State Police*, 491 U.S. 58, 65 (1989). Resolving those who-gets-to-decide questions is hardly a new project for this Court; and while the tide of federal power has ebbed and flowed over the years, some principles, including the "clear statement" requirement, have remained firm for many years. *See, e.g., Reid v. Colorado*, 187 U.S. 137, 148 (1902) (even when Congress may supercede the police powers of the States, Court will never

hold that it has done so unless "its purpose to effect that result is clearly manifested").

Thus, the issue actually presented here reduces to a straightforward question of statutory construction governed by the long-established "clear statement" rule: Does the CSA clearly empower the Attorney General to overrule a state law determination about specific medical uses of controlled substances that concededly have approved medical uses under the CSA?

In asserting that the CSA does precisely that, the Attorney General focuses his attention on controlled substances. He insists that Congress has given him plenary authority over all permissible uses of those substances: that he can reschedule them virtually at will, Pet. Cert. 14, 16; and that he can tell doctors what substances they can prescribe for what medical purposes by decreeing that any specific use of which he disapproves is not a "legitimate medical purpose." *Id.* at 17.[9] Consequently, he asserts, the courts must defer to the Ashcroft Directive.

In Oregon's view, by contrast, this case is about the practice of medicine, an area of traditional state regulation. As this Court explained in *Solid Waste Agency*, an executive official is entitled to the deference petitioner claims only when Congress granted that official authority

[9] The petition asserts without qualification, for example, that the Attorney General's decision about whether a particular use, apparently *any* particular use, of a controlled substance is a "legitimate medical" use is binding on every State. Pet. Cert. 17.



to act in the arena in question. 531 U.S. at 172-73. And while Congress has granted the Attorney General broad authority over controlled substances, the CSA lacks any suggestion that it intended to appoint the Attorney General as a national medical review board, with general authority to re-determine the validity of every prescription that conforms to state law.

Thus, *Solid Waste Agency* holds that the proper inquiry begins a step earlier than the Attorney General would have it. Because this case is about regulating the practice of medicine, an area traditionally and historically within the States' regulatory powers, the starting point is to ask whether the CSA contains a clear statement of Congressional intent to allow the Attorney General to displace that traditional power. Petitioner's predecessor in office, the District Court, and the Court of Appeals all concluded that it does not. That is, each concluded that the CSA simply lacks the "clear statement" of Congressional intent that would be necessary to grant the Attorney General authority to alter the existing balance of state and federal power inherent in the recognition that regulating the practice medicine has always been a matter for the States. And in the absence of that clear statement, petitioner has no legitimate claim to deference.

The Attorney General's claim to deference in this case also ignores at least one significant aspect of the CSA. When originally enacted, the CSA provided that the Attorney General was *required* to register a physician if that physician "is authorized to dispense drugs * * * under the law of the State in which he practices." *Moore*, 432 U.S. at 140. Congress amended the CSA in 1984 to

authorize the Attorney General to deny or revoke a registration found to be contrary to the "public interest." 21 U.S.C. § 823(f). As the Court of Appeals correctly explained, the 1984 amendments to the CSA were not intended to broaden the Attorney General's authority by permitting him to sanction physicians whose conduct conformed to state laws. Pet. App. 19a-20a (quoting S. Rep. No. 98-225, 98th Cong., 2d Sess. (1984), *reprinted in* 1984 U.S.C.C.A.N. at 3449). Rather, Congress intended only to respond to the ineffectiveness of some state licensing boards, which were failing to act against physicians who violated state laws. *See* S. Rep. No. 98-225 at 260-62, *reprinted* in 1984 U.S.C.C.A.N. at 3442-44. In other words, Congress did not intend to authorize the Attorney General to sanction physicians whose conduct was consistent with state law; it intended only to permit him to act where state regulators failed to revoke the licenses of those who violated those state laws. [10]

a. That regulating the practice of medicine is within the scope of the States' historic police powers is hardly open to debate. "Because these are primarily, and historically,

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[10] Moreover, the "legitimate medical purpose" regulation, 21 C.F.R. § 1306.04(a) (1971), was written when the CSA expressly required the Attorney General to defer to state regulators and register any physician licensed by a State to dispense controlled substances. 21 U.S.C. § 821(f) (1970). Reliance on that regulation as a source of authority to override state regulators, therefore, seems particularly suspect; when that regulation was originally enacted, it necessarily could not have been viewed as a source of authority to sanction physicians who acted in accordance with state law.



matters of local concern, the States traditionally have had great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Medtronic, Inc. v. Lohr,* 518 U.S. 470, 475 (1996) (citations, internal quotation marks, ellipses, and brackets omitted); *accord Hill v. Colorado*, 530 U.S. 703, 715 (2000). The Attorney General's only counter-argument is to assert that "there *is* no tradition" of States permitting physicians to aid competent, terminally-ill adults to choose the manner of their own impending death. Pet. Cert. 21, *citing Glucksberg* (emphasis by petitioner). But that poses the question at the wrong level of generality. Nothing in this Court's cases suggests that the proper question is whether the specific case, matter, or practice is within the States' historic powers. Rather, the Court has consistently protected state prerogatives in "traditionally sensitive *areas*." *Will*, 491 U.S. at 65 (emphasis added). In other words, the petition offers no support for its implicit assertion that a State's choice to exercise, or decline to exercise, its police powers in an unusual, or even unprecedented, manner takes that choice out of the historic realm of state power.

b. That the CSA does not contain a "clear statement" of intent to authorize the Attorney General to determine what uses state-licensed doctors may make of substances that concededly have approved medical uses should not be controversial either. The few scraps of the CSA's text the Attorney General cited in the Court of Appeals are absent from the petition filed in this Court. Instead, the petition relies upon generalizations about the Act's structure; the unremarkable assertion that the Attorney General's decisions establish national standards when he ex-

ercises authority Congress clearly has assigned to him; and an inapposite attempt to compare this case to *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001), and *Raich v. Ashcroft*, 352 F.3d 122 (9th Cir. 2003), *cert. granted* 124 S. Ct. 2909 (2004), both of which involve an express Congressional determination that marijuana has no accepted medical uses. Pet. Cert. 13-16, 26.[11]

The Attorney General also purports to find support for his claims about the statute's meaning in *United States v. Moore*, in which, he asserts, this Court concluded that the CSA intended to define a uniform national standard for the use of controlled substances in medical care. Pet. Cert. 17-18 and n. 5. But the question presented in *Moore* was not whether Congress intended to displace the States' police powers to regulate the practice of medicine.[12] While the Court did note the District Court's jury instruction that referred to medical practice

[11] The Attorney General also asserts, emphatically but without supporting authority or analysis, that the use of controlled substances authorized by the DWDA "*is* drug abuse." Pet. Cert. 23 (emphasis by petitioner). That assertion cannot be squared with Congress' description in the CSA of drug abuse as resulting from a drug's "stimulant, depressive, or hallucinogenic effect on the central nervous system." 21 U.S.C. § 811(f).

[12] The Court described the question presented in *Moore* as "whether persons who are registered under the [CSA], 21 U.S.C. § 801 *et seq.*, can be prosecuted under § 841 for dispensing or distributing controlled substances." 423 U.S. at 124.



"generally recognized and accepted in the United States," 423 U.S. at 139, Dr. Moore was prosecuted in the United States District Court for the District of Columbia. *See United States v. Moore*, 505 F.2d 426 (D.C. Cir. 1974). Consequently, there was no state law to apply. Thus, it appears to be a significant overstatement to contend that the Court's opinion in *Moore* means that Congress intended to establish "a national standard for professional practice under the CSA." Pet. Cert. 18, n 5.

3. This Court already has determined how disputes like this one—disputes over whether this case is about federal authority over controlled substances or about state authority over the practice of medicine—must be resolved. The Court has explained that where federal administrative action pushes the boundaries of Congressional power and alters the traditional state-federal balance, Congress must address the precise question at issue before the Court will defer to that administrative action. *Solid Waste Agency*, 531 U.S. at 172-73. And even where Congress includes an express preemption provision—as opposed to the express disclaimer of preemptive intent contained in the CSA[13]—the Court seeks out the "domain *expressly*

[13] Title 21, section 903, of the United States Code states:

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of

pre-empted" by the specific language Congress chose, *Medtronic, Inc.*, 518 U.S. at 484 (emphasis added; internal quotation marks omitted); it does not assume that the mere inclusion of such a clause reflects Congressional intent to pre-empt in every respect. *Id.* at 485. Presuming that Congress did not intend to pre-empt state police power regulations "is consistent with both federalism concerns and the historic primacy of state regulation of matters of health and safety." *Ibid.* In other words, it is insufficient for a federal official merely to point to his or her general authority, such as the Attorney General's generalized authority over enforcement of controlled substance laws, when the exercise of that authority would displace traditional state powers such as regulating the practice of medicine. Something much more specific than anything in the CSA—such as a clear statement that Congress intended to give the Attorney General authority to displace state regulations about what specific uses may be made of controlled substances that admittedly have beneficial medical uses, or that it intended to prevent the use of controlled substances for purposes authorized by the DWDA—would be required here.[14]

4. In sum, the petition offers slight support for its assertion that the Court of Appeals has overturned the federal

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this subchapter and that State law so that the two cannot consistently stand together.

[14] Congress twice attempted and twice failed to enact laws that expressly would have pre-empted the DWDA. H.R. 4006, 105th Cong. (1998) ("Lethal Drug Abuse Prevention Act of 1998"); H.R. 2260, 106th Cong. (1999) ("Pain Relief Promotion Act of 1999").



structure or even that the court's opinion is open to serious question, and there appears to be little reason why this Court should grant review here. Although the opinion of the Court of Appeals sparked a dissent, the majority's resolution does not conflict with any decision of any other circuit. Although Oregon and the Attorney General disagree about the proper starting point for the analysis in this case, this Court has resolved that question and the disagreement here does not affect any other State or any other federal statute. Although the division of responsibilities between the state and national governments is a matter of continuing and vital interest in our federal system, the question presented by this case is hardly unique and involves nothing more than the application of settled principles. And although the policy choice underlying the DWDA is unquestionably both pioneering and controversial, that choice is not at issue in this case.

## CONCLUSION

This Court should deny the petition for a writ of certiorari.

Respectfully submitted,

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January 10, 2005

Office of the Attorney General
Washington, D.C. 20530

June 5, 1998

The Honorable Henry J. Hyde
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request concerning the question whether the Department of Justice, through the Drug Enforcement Administration ("DEA"), may invoke the Controlled substances Act ("CSA"), 21 U.S.C. §§ 801-971, to take adverse action against physicians who assist patients in ending their lives by prescribing controlled substances. The issue has arisen in the context of Oregon's "Death with Dignity Act." Oreg. Rev. Stat. §§ 127.800-127.995, which permits physicians to assist competent, terminally ill patients in ending their lives in compliance with certain detailed procedures. The Department has reviewed the issue thoroughly and has concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA.

The Oregon Act was approved by Oregon voters on November 8, 1994, and went into effect on October 27, 1997. The Act provides for a detailed procedure by which a mentally competent, terminally ill patient may

request to end his or her life "in a humane and dignified manner." O.R.S. § 127.805. The procedure requires, for example, that the patient's competence and the voluntariness of the request be documented in writing and confirmed by two witnesses, see id. § 127.810(1), that the patient's illness and competence and the voluntariness of the request be confirmed by a second physician, see id. § 127.820, and that the physician and patient observe certain waiting periods, see id. §§ 127.840, 127.850. Once a request has been properly documented and the requisite waiting periods have expired, the patient's attending physician may prescribe, but not administer, medication to enable the patient to take his or her own life. As a matter of state law, physicians acting in accordance with the Oregon Act are immune from liability as well as any adverse disciplinary action for having rendered such assistance.

Prior to the Oregon act's taking effect last year, you wrote to DEA Administrator Thomas Constantine seeking the DEA's view as to whether delivering, distributing, dispensing, prescribing, or administering a controlled substance with the intent of assisting in a suicide would violate the CSA notwithstanding a state law such as the Oregon Act. In response, Administrator Constantine explained that "physician-assisted suicide would be a new and different application of the CSA," and that the determination whether to pursue adverse action under the CSA would first require "a medico-legal investigation" involving "state and local law enforcement agencies and prosecutors." He also stated, however, that "the activities that you described in your letter to us would be, in our opinion, a violation of the CSA." Subsequently, many



other Members of Congress have sent letters urging that I support the DEA's conclusions and enforce federal laws and regulations accordingly. I have received other correspondence supporting a contrary conclusion.

The Department has conducted a thorough and careful review of the issue of whether the CSA authorizes adverse action against a physician who prescribes a controlled substance to assist in a suicide in compliance with Oregon law.

The CSA is a complex regulatory scheme that controls the authorized distribution of scheduled drugs. Physicians, for example, are authorized to prescribe and distribute scheduled drugs only pursuant to their registration with the DEA, and the unauthorized distribution of drugs is generally subject to criminal and administrative action. The relevant provisions of the CSA provide criminal penalties for physicians who dispense controlled substances beyond "the course of professional practice," 21 U.S.C. § 802(21), see id. § 841(b), and provide for revocation of the DEA drug registrations of physicians who have engaged either in such criminal conduct or in other "conduct which may threaten the public health and safety," id. § 823(f). Because these terms are not further defined by the statute, we must look to the purpose of the CSA to understand their scope.

The CSA was intended to keep legally available controlled substances within lawful channels of distribution and use. See S. Rep. No. 91-613, at 3 (1969). It sought to prevent both the trafficking in these substances for unauthorized purposes and drug abuse. The particular drug abuse that Congress intended to prevent was that deriv-

ing from the drug's "stimulant, depressant or hallucinogenic effect on the central nervous system," 21 U.S.C. § 811(f).

There is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice. Indeed, the CSA is essentially silent with regard to regulating the practice of medicine that involves legally available drugs (except for certain specific regulations dealing with the treatment of addicts, see 42 U.S.C. § 257a; 21 C.F.R. § 291.505).

Even more fundamentally, there is no evidence that Congress, in the CSA, intended to assign DEA the novel role of resolving the "earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide, Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997), simply because that procedure involves the use of controlled substances. If Congress had assigned DEA this role under the CSA, it would ultimately be DEA's task to determine whether assistance in the commission of a suicide, in compliance with a state law specifically permitting and regulating such assistance, nevertheless falls outside the legitimate practice of medicine and is inconsistent with the public interest. These questions, however, are not susceptible of scientific or factual resolution, but rather are fundamental questions of morality and public policy. Such a mission falls well beyond the purpose of the CSA.

The state of Oregon has reached the considered judgment that physician-assisted suicide should be au-



thorized under narrow conditions and in compliance with certain detailed procedures. Under these circumstances, we have concluded that the CSA does not authorize DEA to prosecute, or to revoke the DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law. We emphasize that our conclusion is limited to these particular circumstances. Adverse action under the CSA may well be warranted in other circumstances: for example, where a physician assists in a suicide in a state that has not authorized the practice under any conditions, or where a physician fails to comply with state procedures in doing so. However, the federal government's pursuit of adverse actions against Oregon physicians who fully comply with that state's Death with Dignity Act would be beyond the purpose of the CSA.

Finally, notwithstanding our interpretation of the CSA as it applies to the Oregon Act, it is important to underscore that the President continues to maintain his longstanding position against assisted suicide and any Federal support for that procedure. This position was recently codified when he signed the Assisted Suicide Funding Restriction Act last year. While states ordinarily have primary responsibility for regulating physicians, the President and the Administration nonetheless remain open to working with you and other interested members of Congress on this complex but extremely important issue.

/s/ Janet Reno
Janet Reno

cc: The Honorable John Conyers, Jr.
Ranking Minority Member